INDIANA STATE BOARD OF HEALTH FACILITY ADMINISTRATORS
APPLICATION FOR PRECEPTOR

State Form 49845 (R2 / 2-04)
Approved by State Board of Accounts, 2002
*Social Security number is required pursuant to I.C. 4-1-8-1.

Health Professions Bureau
402 W. Washington St. Room 066
Indianapolis, IN 46204
Telephone: (317) 234-2051
hpb6@hpb.state.in.us

APPLICATION FEE:	
DATE FEE PAID:	
RECEIPT NUMBER:	
PRECEPTOR NUMBER:	
DATE ISSUED:	

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name *(last, first, middle, maiden)*			*Social Security number
Residential address *(number and street or Rural Route)*			
City, state, ZIP code		Email address	
Telephone number *(Daytime)* ( )	Date of birth	Birth place	
HFA license number		Original issuance date (*month, day, year*)	Expiration date (*month, day, year*)
Name of training facility			Facility telephone number ( )
Address of facility (*number and street*)		Type of facility	
City, state and ZIP code			

ADMINISTRATOR-IN-TRAINING INFORMATION

Name of A.I.T. (*last, first, middle, maiden*)

Address of A.I.T. (*number and street*)

City, state, ZIP code

WORK EXPERIENCE

List below all of your work experience for the past three (3) years, starting with your present employment. ***INCLUDE YOUR EMPLOYER, POSITION, TYPE OF BUSINESS, PERIOD OF TIME WORKED, DUTIES, TYPE OF FACILITY (SNF, ICF, ETC.) AND NUMBER OF BEDS IN THE FACILITY.***

(*Continued on the reverse side*)

WORK EXPERIENCE (*continued*)

List all other related experience pertaining to the health facility, administration, and/or other related areas:

Have you ever been qualified as a Preceptor in another state?

☐ Yes ☐ No

If yes, list the state, date of issuance and expiration date.

If your answer is **"yes"** to any of the following, explain fully in a sworn affidavit, including all related details. Include the violation, location, date and disposition. If you have had a malpractice judgement, provide the name of the plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to the application.

1) Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2) Have you ever been denied a license, certificate, registration or permit to practice as a health facility administrator or any regulated health occupation in **any** state or country? ☐ Yes ☐ No

3) Are you now, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No

4) Have you ever been convicted of, pled guilty or nolo contendre to
   A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. To any offense, misdemeanor or felony in any state? ☐ Yes ☐ No
   (*Except for minor violations of traffic laws resulting in fines.*)

5) Have you ever been denied staff membership or privileges in any hospital, or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

6) Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have owned, operated, trained, monitored, managed or acted as a consultant? ☐ Yes ☐ No

7) Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

VERIFICATION

I hereby swear or affirm under the penalties of perjury, that the above statements made in this application including all attachments are true, complete and correct.

Signature of applicant	Date (*month, day, year*)